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GUEST EDITORIAL

Quality of Life

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Traditionally, the success of cancer treatment has been measured by temporal clinical endpoints, particularly long-term, overall, or relapse-free survival, as well as response rate, time to treatment failure, and time to progression. However, as we all know, both the cancer and its treatment have other effects on the patient, particularly in the setting of multidisciplinary care where surgery, radiation therapy, and chemotherapy can each have adverse consequences.

More and more, survival alone is regarded as insufficient to address the success of cancer management. A treatment which improves the quality of life (QOL) can be regarded as effective even if a survival benefit is absent. Here then is the basis for current interest to identify the determinants of the quality of the patient's life and to convert this assessment into a measure which can be applied to the tough choices confronting the patient and physician. QOL might be a subset of, but should be set apart from, ''quality of care,'' the latter addressed to broad-based, usually economically centered, health-related issues.

Most measures of QOL are psychosocially oriented, structured questionnaires which can be scored and quantified. QOL, however, has multiple other dimensions which embrace pain, mobility, capacity for sexual relationships, even cost effectiveness of treatment alternatives, and, depending on the site and nature of cancer treatment, the impact of a stoma, altered urinary function, gastrointestinal disability, loss of a limb, and other effects. The limitations of combining these disparate variables—which encompass morbidity, with personal variations of an idealized life style into a single number or point on a graph—are self-evident. Moreover, many patients have an inherent adaptive capacity which adjusts to adversity and defies measurement. Nonetheless, the aim of encompassing QOL in treatment decisions is worthwhile. Results can impact on our conventional wisdom and direct revision of our current concepts.

For example, one would instinctively believe that breast conservation must be superior to mastectomy for treatment of breast cancer. Studies, however, have found no difference between treatment modalities in QOL, global adjustment, performance status, changes in life patterns, and fears [1,2].

One would intuitively assume that patients with soft tissue sarcoma whose limbs have been amputated would have a poorer QOL than those whose limbs have been spared. Retrospective comparisons of psychologic outcome, however, have not found a difference [3].

There is no doubt that QOL is generally better after anterior resection than after abdominal perineal resection. The advent of ultra-low anterior resection, particularly with preoperative chemoradiation, has increased genitourinary and gastrointestinal side effects, and it seems opportune for a proper comparison with modern stomal construction and management [4].

Almost all existing QOL studies have been performed by nonsurgeons with psychometric support. Although there are QOL comparisons of different chemotherapy regimes for colon cancer, I was unable to find a reliable QOL study of adjuvant therapies for either colon or rectal cancer compared with no treatment. It is time for the surgical oncologist to provide leadership in QOL studies.

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